



The

Safety

Wire

March 2018

NOT EVERYONE IS A SAFETY OFFICER. The

comment is often made, with good intentions, that every member of a flight unit is a safety officer. I feel that this statement underestimates what it takes to be a safety officer. I do agree that every member of the unit has a responsibility to play an active role in the safety system. It is



critical that unit members look for safety issues and report them to the safety officer. No safety measure is effective without the honest effort of unit members to understand and apply the measure to see if it will work, and then provide feedback from the field. Usually, one of the most difficult tasks a safety officer struggles with is getting unit members to participate in the program.

Some unit members will be asked to be part of the safety committee. That requires more than just showing up and nodding one's head occasionally to make sure the meeting continues as fast as possible to adjournment.

Those involved in managing the unit play an important part as well. Managers need to support the safety officer through ownership of the safety program, adherence to Just Culture policy and securing required resources. An overlooked responsibility of management is making sure the safety officer receives the training they need to do the job properly.

Being a safety officer is so much more than just being aware of the safety issues at an organization. It involves more processes than bringing the issue up to management or trying to be as safe as possible during daily activities. Being a safety officer means knowing how to go beyond the obvious when looking for hazards. It means understanding how to assess risk and analyze a hazard for direct and latent factors. Safety officers have to

develop effective risk controls that go beyond, "This is risky, so don't do it." They have to coordinate program efforts with managers, training officers, and all members of the organization. Effective safety officers know how to calculate return on investment, risk control performance, and probability of success. The list goes on and on.



These are not things that everybody in the unit is doing. Nor should they. All of this effort takes a significant amount of time and effort....and training.

Everyone in the unit is a part of the safety program, and each person's interaction with it (or lack of interaction) directly influences the effectiveness of the program. The safety officer has specific responsibilities in managing the health of the operation. Without providing proper training to the safety officer, the program will never be as healthy as it could be.

THE SMALLEST AMOUNT OF VANITY IS FATAL IN AEROPLANE FLYING. SELF-DISTRUST RATHER IS THE QUALITY TO WHICH MANY A PILOT OWES HIS PROTRACTED EXISTENCE.

*~ CAPT. EDDIE RICKENBACKER
U.S. TOP SCORING ACE, WWI*

APSA ONLINE MEETINGS

The schedule for upcoming APSA online meetings is as follows.
If you would like to join, send an email to: Safety@PublicSafetyAviation.org



UAS:

Wednesday, April 11, 2018
1:00 PM - 2:00 PM EDT (1800
UTC)

Safety Officers:

Friday, April 13, 2018
1:00 PM - 2:00 PM EDT (1800
UTC)

Maintenance:

Friday, April 27, 2018
1:00 PM - 2:00 PM EDT (1800
UTC)

TOWERING GENIUS DISTAINS A BEATEN PATH. IT SEEKS REGIONS HITHERTO UNEXPLORED. IT SCORNS TO TREAD IN THE FOOTSTEPS OF ANY PREDECESSOR, HOWEVER ILLUSTRIOUS.

~ ABRAHAM LINCOLN

REALITY CHECK...

Note: The following reports are taken directly from the reporting source and edited for length. The grammatical format and writing style of the reporting source has been retained. My comments are added in **red** where appropriate. The goal of publishing these reports is to learn from these tragic events and not to pass judgment on the persons involved.

Aircraft: AS 350BA
Injuries: None
ATSB#: AO-2017-074

https://www.atsb.gov.au/publications/investigation_reports/2017/aair/ao-2017-074/

An Airbus AS350-BA helicopter was chartered to conduct a flight to the Jack Rabbit Vineyard helicopter landing site (HLS). At about 1415, while landing, the tips of the helicopter's main rotor blades struck an encroaching bush.

At about 1310, the pilot volunteered at short notice to conduct the charter flight to the Jack Rabbit Vineyard. As the pilot had not previously flown to this HLS (a tennis court), he discussed the landing site with another experienced company pilot. Their discussions included consulting *Google Earth* and ascertaining the safest way in and out of the landing site.

On arrival, the pilot recognized the features of the HLS from his pre-flight planning and conducted a north-to-south, downwind approach, which was appropriate for the conditions on the day. During the approach, the pilot identified the key boundaries of



the landing site, which included a brick wall at the southern end of the site, but he did not see a large bush that encroached into the HLS. When established in the HLS, and believing that he had to make way for another helicopter, the pilot slowly hover-taxied the helicopter forward towards the south-west corner of the landing site. During this, the pilot reported that he remained focused on the brick wall ahead.

The pilot reported that, as the HLS was easily recognizable from his pre-flight planning and due to over-confidence, he elected to abbreviate the usual 360° reconnaissance of the site. Instead, he conducted a sweeping 270° turn about the HLS, prior to his downwind approach into the landing



site. The approach to the centre of the HLS was as anticipated.

Before maneuvering within the HLS, the pilot ensured that the area around the helicopter was free of obstacles, but acknowledged that he did not notice the bush and how far it encroached into the landing site. The pilot commented that he was focusing on the brick wall as he moved forward and had discounted the right side of the helicopter.

Aircraft:	Cessna 182T
Injuries:	2 Fatal
NTSB#:	WPR18FA084

<https://app.nts.gov/pdfgenerator/ReportGeneratorFile.aspx?EventID=20180206X32714&AKey=1&RType=HTML&IType=FA>

Video: https://www.nbcsandiego.com/on-air/as-seen-on/santeecrashVidEdit_San-Diego-472978183.html

A Cessna 182T airplane impacted into an industrial storage facility. The private pilot, one passenger, and a family dog were fatally injured; another family dog was not injured. The airplane was substantially damaged throughout the structure. The pilot/owner operated the airplane under the provisions of Title 14 Code of Federal Regulations Part 91, as a personal cross-country flight. Instrument meteorological conditions prevailed at the time of the accident and a visual flight rules (VFR) flight plan had been filed.

The tower at SEE was not open at the time the airplane departed; however, off-duty controllers were in the tower that was to open at 0700. One of the controllers who witnessed the accident called 911. Witnesses in the surrounding area reported the presence of a low-level fog.

The accident flight was captured on video, and showed the airplane make a turn back to the east toward the airport. The airplane was observed entering and exiting the fog before the airplane entered a spin, and dropped below the roof-tops of several buildings.

Witnesses reported that the engine was not sputtering or backfiring but did sound like it was revving. They further reported that in the turn back to the east, the airplane was in a nose-high attitude, with the wings rocking back and forth before it started to spin and impact the ground.

Aircraft:	Airbus AS 355 F1
Injuries:	5 Fatal
AAIB#:	EW/C2017/03/02

<https://www.gov.uk/aaib-reports/aaib-investigation-to-airbus-helicopters-as355f1-ecureuil-ii-g-ohcp>

<http://www.bbc.com/news/uk-wales-43321682>

The helicopter was flying on a Visual Flight Rules (VFR) flight plan. The weather on departure was suitable for VFR flight but, as forecast, deteriorated markedly in the area of Snowdonia with low cloud and rain. The helicopter flew over a witness 4.3 nm southeast of the accident site before disappearing into the cloud. Shortly afterwards it struck the east side of Rhinog Fawr Mountain, fatally injuring the five occupants.

At what he estimated was between 1130 and 1150 hrs, a witness was located in Coed Brenin Forest, 4.3 nm southeast of the accident site. He saw a helicopter pass overhead and watched it for some 5 - 10 seconds before it went into the cloud cover. He reported the elevation of his position as 120 m (400 ft) at which time the helicopter was at 2,500 ft. A replay of the radar tape for the appropriate time, showed only G-OHCP in the area and flying on its track with no other aircraft in the vicinity.

The helicopter had been in a gentle descent from its maximum height to 2,500ft before descending to 2,060ft when it struck the east side of Rhinog Fawr Mountain, at about 1157 hrs. At the moment of impact, the auto pilot was engaged with the heading (HDG), turn coordinator (T/C) and vertical speed (V/S) modes active. This was consistent with a pilot-managed, autopilot- own descent.

It is therefore possible that having entered the cloud, his mental picture was that he had adequate height to descend and regain VMC. However, if he did check the terrain ahead from his chart or iPad he may have then been aware of the rising ground. Given that the cloud would have meant the pilot was now flying in IMC and as the helicopter's GNS430 was not fitted with the terrain warning modification, there was no other means of warning the pilot of the rising ground.

There are no new ways to crash an aircraft...

...but there are new ways to keep them from crashing.

Safe hunting,

Bryan 'Mug' Smith

Safety@PublicSafetyAviation.org

407-222-8644

